Department of Health and Human Services
Health Care Financing Administration
Operational Policy Letter #89
OPL 99.089

Date: April 23, 1999

To: Current M+C Organizations X

Section 1876 Cost Plans[1] X

CHPP Demonstrations

Evercare X

DoD (TriCare) X

SHMO I & II X

PACE

OFM Demonstrations

MSHO

W.P.S.

HCPPs

Federally Qualified HMOs

[1] *This OPL is intended primarily for M+C organizations and any other demonstration projects for which the BBA statutory provisions and related regulations are applicable. Some information included in this OPL however does apply to Section 1876 cost contractors. For example, Section 1876 cost contractors must submit a BIF2000 by July 1, 1999 so that information on benefits may be included in HCFA's publication of plan benefit information.*

Subject: CONTRACT YEAR 2000 *MEDICARE+CHOICE* INSTRUCTIONS

Executive Summary of Important Changes for the Contract Year 2000

HCFA Payment to Medicare + Choice (M+C) Organizations

The Balanced Budget Act (BBA) of 1997 requires that HCFA implement, beginning on January 1, 2000, a methodology involving risk adjusted payments to M+C organizations. The new methodology accounts for variation in per capita costs based on the health status and demographic factors of Medicare beneficiaries. Risk adjustment looks at a person=s inpatient diagnoses in one year and predicts Medicare expenditures for that person the next year. Predicted expenditures are converted to relative risk factors; these factors are then applied to the appropriate M+C county rates. This payment method is designed to help ensure that HCFA pays the proper amount to health plans for the beneficiaries they serve by recognizing the health status and projected utilization of an organization=s enrollees.

In order to ensure that organizations have time to adjust to the new payment method, HCFA established a five-year transition period for the risk adjustment methodology. In contract year (CY) 2000, only 10 percent of an organization=s payment for each beneficiary will be calculated based on the new risk factors, while 90 percent of the payment for each beneficiary will be based on the current system. The full effects of risk adjustment will be phased in by 2004.

The risk adjustment methodology for CY 2000 relies on the Principal Inpatient Diagnostic Cost Group (PIP-DCG) model. This model uses inpatient hospital diagnoses from the period July 1, 1998 through June 30, 1999 to determine the *risk factors* for CY 2000. Additional, detailed information on the PIP-DCG model and HCFA=s plans for implementation of risk adjustment are described in the AAdvance Notice of Methodological Changes for the CY 2000 Medicare+Choice Payment Rates@, published on January 15, 1999. This information can be located at h*ttp://www.hcfa.gov/stats/hmorates/45d1999/45day.htm*. On March 1, 1999 HCFA published the A *Announcement of Calendar Year (CY) 2000 Medicare+Choice Payment"* which contains the HCFA payment rates to M+C organizations for CY 2000. This important information can be located on the HCFA web site at *http://www.hcfa.gov/stats/stats.htm.* Also on March 1, HCFA mailed to individual M+C organizations a letter that estimated the impact of the new payment method on M+C contracts.

Changes to the Medicare+Choice Program -- Final Regulation

On February 17, 1999, the Health Care Financing Administration published in the Federal Register several important changes to the Medicare+Choice program. This final rule addresses selected issues raised by public comment on the June 26, 1998 interim final rule, particularly in areas where HCFA recognized the need for changes or where HCFA believed that clarifications were needed as soon as possible. Among the issues addressed in this final rule are several access-related issues, including initial care assessment requirements, required notification to Medicare beneficiaries when specialists are terminated from an M+C plan, and certain provider requirements. These new rules became effective on March 19, 1999**.**

One specific change relates to HCFA requirements for notifying Medicare enrollees of program changes. New regulatory provisions require that M+C organizations notify all Medicare enrollees by October 15, 1999 of any plan policy and benefit changes that are scheduled to take effect on January 1, 2000. Under this policy, an M+C organization would submit its Annual Notice of Coverage (ANOC) for HCFA Regional Office review by September 1, 1999 in order to allow for the 45-day review period required under 42 C.F.R. §422.80(a)(1). This will ensure that current enrollees (and upon request, prospective enrollees) will receive accurate information about all plan rules in time for the annual election period beginning November 1, 1999, as well as promote coordination in the information distribution efforts by HCFA and M+C organizations. Prior to this change, regulations at 42 C.F.R. §422.111(d)(2) required only that M+C organizations notify Medicare enrollees at least 30 days prior to the intended effective date of any change in plan rules.

Change in the Deadline for Submitting ACRs, Benefit Proposals, and Nonrenewal Notices

We understand that the revised schedule under the BBA for M+C organizations to make decisions on contract year 1999 renewals, benefits, premiums and service areas presented a number of difficulties, and resulted in some organizations deciding not to renew contracts in whole or part. Congressional leaders have recognized this problem, and have indicated their support for proposals in the President's FY 2000 budget to change the deadline for submitting Adjusted Community Rate (ACR) information, and other benefit information from May 1 to July 1. In addition to informing us that they intend to enact these changes, these Congressional leaders have encouraged HCFA to operate for 2000 as if these changes were in effect, on the assumption that statutory authority will be enacted, even if retroactively[2]. In light of these changes, we are hereby informing M+C organizations,

[2] *On April 7, 1999, HCFA issued a notice to all M+C organizations informing them that they may submit ACRs for CY 2000 beginning May 1, but not later than July 1, 1999.*

pursuant to our discretion under 42 C.F.R. §422.506(a)(3), that we will accept non-renewal notices for 2000 on or before July 1, 1999.

We believe this new time frame affords M+C organizations the necessary additional time to collect more complete data to project product costs and evaluate other meaningful market conditions before making strategic decisions on changes in premiums, benefits and service areas. At the same time, the July 1 date allows HCFA additional time to review and approve all premium and benefit proposals (ACRPs), and develop and provide accurate information to Medicare enrollees prior to the Annual Election Period.

M+C organizations may begin submitting ACR and BIF2000 proposals beginning May 1, 1999. We encourage organizations to submit ACRPs prior to July 1, to assist us in completing our review and beneficiary publications and to allow us additional time to begin our review of CY 2000 marketing materials.

CY 2000 Contract with HCFA

Last year, HCFA entered into a one year transitional contract with M+C organizations based on interim final M+C regulations. Because this contract was designed to be in place for 1999 only, any M+C organization that has not provided a timely notice of non-renewal, and is determined by HCFA to be eligible for a renewal, will receive a new, revised contract to sign for 2000. In developing the 2000 contract, HCFA will work closely with the Office of the Inspector General, the Department of Justice, and industry representatives in considering comments received on the 1999 transitional contract. We anticipate a few minor changes to the Year 2000 contract as a result of this process. Any changes in the Part C final rule published after July 1 that significantly affect plan requirements will not apply to CY 2000. Any new requirements will be reflected, if necessary, in the M+C contract beginning 2001.

We intend to make available the new Year 2000 contract in early May, 1999, with the expectation that all M+C organizations planning to contract in 2000 will enter into a Year 2000 agreement by July 1, 1999. Refusal to enter into a Year 2000 contract with HCFA by July 1 will be construed as notice of an intent to nonrenew under 42 C.F.R. §422.506(a)(3). Pursuant to §422.506(a)(4), unless there are special circumstances that warrant special consideration, as determined by HCFA, we may not enter into a subsequent M+C contract, for a period of five (5) years, with an M+C organization who chooses to nonrenew or terminate its contract with HCFA.

Changes in ACR and Benefit Filing Formats

As included in the Part C regulation and discussed at the ACR training seminar in November of last year, HCFA will implement a new ACR format for the contract year 2000. However, HCFA has decided to delay the full implementation of the Plan Benefit Package (PBP) -- the

anticipated new format for use in submitting benefit data to HCFA -- until CY 2001.

The new ACR forms are designed to price a set of M+C plan benefits offered and calculate, as required by current law, excess amounts and additional benefits required, if any. HCFA will approve the actual benefits, cost sharing amounts, and premiums for each M+C plan. The actual, approved ACRPs must be offered by M+C organizations in CY 2000[3]. In prior years, the ACR focused primarily on the calculation of a maximum premium amount for proposed benefit packages.

HCFA will conduct a pilot test of the PBP in CY 2000 to ensure that the new benefit entry system is responsive to the needs of M+C organizations while allowing HCFA to use the information for reviewing ACRs, publishing Medicare Compare information, and reviewing marketing materials, for example. HCFA is planning for full implementation of the PBP for CY 2001. In the interim, M+C organizations will be asked to submit all benefit information for CY 2000 using a revised tool, the BIF2000[4]. The BIF2000 combines the BIF with the Medicare Compare data and reflects the new BBA requirements.

Y2K in Managed Care

HCFA is working with managed care organizations to assure that they are Y2K compliant. In addition to submitting attestations to HCFA, as discussed in previous HCFA communications, managed care organizations are required to submit contingency plans to HCFA by July 15, 1999. Additional information will be forthcoming about HCFA's plans to conduct on-site Y2K visits to selected managed care organizations.

Significant Dates for the CY 2000

The following are significant dates and associated activities which related to the CY 2000 M+C program. Additional information on many of these activities will be forthcoming. All the following dates are in 1999.

Feb. 17 -- Publication of final rule entitled "Medicare Program: Changes to the Medicare+Choice Program"

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[3] *As noted in the section entitled "Enhancements to M+C Plans", HCFA will not approve changes to M+C plans prior to the contract year, or January 1. Therefore, organizations should submit only valid benefit proposals based on the organization's best estimates of plans costs.*

[4] *M+C organizations who volunteer for participation in the PBP pilot must also submit a BIF2000 for each M+C plan. Submission of a PBP for the pilot test does not replace the requirement to submit a BIF2000.*

March 1	--	Release of the CY 2000 *Medicare+Choice* capitation payment rates
	--	Release of individual risk adjustment notifications to M+C organizations
	--	ACR and BIF2000 forms and instructions available for download at *www.fu.com/hpms*.
March 9	--	ACR one-day training seminar, Baltimore, MD
March 19	--	Effective Date of Changes made in February 17 final rule
April 1	--	**M+C organizations required to begin collecting data on beneficiary grievances and appeals. (see OPL 99.081)**
April 8-13	--	Instructions and training for the Plan Benefit Package (PBP) pilot participants
April 15	--	Provider contracting implementation plans due to HCFA *(Note: this date clarifies related language in OPL #077 -- "Medicare + Choice Provider and Administrative Contracting Guidance")*
May 1	--	HCFA, HPMS software available to begin accepting ACRP submissions at *www.fu.com/hpms*
Early May	--	HCFA notifies M+C organizations of intent to renew M+C contract pursuant to regulations at 42 C.F.R. 422.504(c)(1). M+C contract sent to M+C organizations for signature. *(Note: in light of the delay in publishing the HCFA guidelines for compliance plans, HCFA will not consider an organization's progress in implementing these plans as of May 1, as noted in Article III, Section F of the 1999 Medicare+Choice Contract with HCFA)*
May 10	--	Deadline for requesting consolidation of M+C contract numbers (i.e. H#s)
May 11	--	ACR one-day training seminar, Baltimore, MD
June 1	--	Tentative date for publishing standardized Summary of Benefits format and related HCFA guidance
June 15	--	Deadline for submitting requests to HCFA to consolidate medical costs included in CY 2000 ACRP

June 30	--	HEDIS data on prior year services (calendar year 1998) due to HCFA contractor (NCQA)
	--	Tentative date for releasing HCFA guidelines on compliance plans based on regulatory requirements at 42 C.F.R. 422.501(b)(3)(vi).
May 1 to June 30	--	PBP pilot organizations submit requirements and checklist to HCFA
July 1	--	Administrative deadline[5] for submitting Adjusted Community Rate Proposals (ACRP), BIF2000 information and service area information
	--	**Administrative deadline for notifying HCFA of intentions to nonrenew an M+C Contract[6] or to reduce service areas**
	---	M+C organizations sign and return M+C contract to HCFA
	--	Deadline for submitting Year 2000 Capacity Limits
July 1-Aug 1	--	PBP pilot organizations submit data to HCFA
July 15	--	M+C organizations submit Y2K contingency plans to HCFA
July 15-July 23	--	M+C organizations preview *Medicare & You* handbook items
Sept 1	--	HCFA begins Year 2000 Local Information Campaign

[5] *HCFA will allow organizations until July 1, 1999 to submit ACRPs for CY 2000. HCFA will not allow health plans to make changes to their benefit and premium proposals (i.e. ACRP) after the July 1 deadline. HCFA will only allow changes <u>required</u> by HCFA auditors as necessary to approve the requested benefits. For example, HCFA auditors could require adjustments to cost estimates or premium calculations submitted as part of the ACR but would not necessarily require revisions to proposed benefits*

[6] *Pursuant to regulations at 422.506(a)(3), HCFA will allow a M+C organization until July 1, 1999 to notify HCFA of its plans not to renew its M+C contract with HCFA as of January 1, 2000. After July 1, 1999, HCFA will not accept written notices of nonrenewal of expiring M+C contracts.*

	--	Marketing materials (for ANOC) due to HCFA Regional Offices in order to meet October 15th deadline[7]
Sept 1-3	--	M+C organizations preview Medicare Compare plan data

[7] *HCFA is currently considering alternative plans for reviewing and approving certain marketing materials related to annual benefit changes prior to HCFA's scheduled release of Medicare Compare information on the Internet (or prior to September 15, 1999)*

Sept 10	--	Deadline for submitting encounter data to the plan's fiscal intermediary (FI) from the period July 1, 1998 through June 30, 1999[8] *(See additional information below)*
Sept 15	--	HCFA publishes Medicare Compare information on Internet
	--	Deadline for notifying members who are affected by decisions to nonrenew contracts and reduce service areas in Year 2000 (Y2K risk mitigation plan)
Sept 15 - Oct 15	--	*Medicare & You* Handbooks mailed to beneficiaries
Oct 1	--	Anticipated publication of data collection instructions for HEDIS /CAHPS/ HOS for year 2000
Oct 15	--	New[9] regulatory deadline for notifying Medicare enrollees of Year 2000 benefit and program changes[10]
Nov 1- Nov 30	--	Annual Open Enrollment Period (*All M+C Organizations)*

Important Reminders Regarding Submission of Encounter Data

[8] *Encounter data received after September 10, 1999, but before June 30, 2000, will be considered as part of the reconciliation process. The encounter data reconciliation process for CY 2000 will not be conducted until after December 31, 2000.*

[9] *Included in final regulations published on February 17, 1999*

[10] *The October 15 deadline for notifying members of plan changes does not pertain to organizations who will nonrenew contracts or reduce service areas. These organizations must notify all members by September 15.*

As indicated in the January 15, 1999 notice regarding HCFA's payment methodology, organizations can submit encounter data using either the full UB-92, version 5.0, or the abbreviated UB-92, version 5.0. The abbreviated format can be used for discharges **of Medicare enrollees from hospitals** through December 31, 1999. All data in the abbreviated format for discharges through December 31, 1999 must be submitted by March 31, 2000 and must be Y2K compliant. The full UB-92 will be required for all discharges of enrollees on or after January 1, 2000.

By September 10, 1999, all M+C organizations must submit to HCFA all encounter data for the period July 1, 1998 through June 30, 1999. HCFA is unable to extend this deadline without jeopardizing our ability to implement risk adjustment by January 1, 2000. In order to meet this deadline, organizations should submit encounter data on at least a monthly basis to their Fiscal Intermediary (FI).

However, HCFA will institute a reconciliation process to account for late data submissions. HCFA will continue to accept late encounter data for the period July 1, 1998 through June 30, 1999 until June 30, 2000. Therefore, if health plans receive UB-92s from hospitals after this date, they may submit the encounter to their FI in the appropriate format for processing. The FI will not accept late data after June 30, 2000. After the payment year is completed, HCFA will recalculate the risk factors for affected individuals to determine if adjustments to payments are necessary.

Important Information Regarding Nonrenewals and Service Area Reductions

Pursuant to 42 C.F.R. §422.506(a)(3), HCFA will allow M+C organizations until July 1, 1999 to notify HCFA that it will nonrenew its M+C contract with HCFA as of January 1, 2000[11]. HCFA also requires M+C organizations to notify it by July 1, 1999 of any plans to withdraw certain counties from its approved M+C service areas. Notifications to HCFA must be made in writing as required at 42 C.F.R. §422.506(a)(2)(I)[12].

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[11] *M+C organizations who do not notify HCFA of their intent to nonrenew and/or who enter into a Medicare+Choice contractual agreement for CY 2000 are required to honor that commitment for the Year 2000. HCFA anticipates that an organization's contracts with providers will be fully renewed, or written agreements to accept members based on fee-for-service payment rates will be completed, by January 1, 2000 to ensure compliance with regulations. In certain cases, an organization may submit a request for a capacity limit, or amend an approved capacity limit, in order to control enrollment.*

[12] *In addition to this notice, M+C organizations who intend to reduce M+C plan service areas must indicate this intention, and identify the affected service areas, when submitting the ACR/BIF2000.*

M+C organizations should send all notification to nonrenew a M+C contract and/or reduce a M+C plan service area to:

Mr. Gary Bailey
c/o Ms. Cheryl Bitoun
Health Plan Purchasing and Administration Group
Center for Health Plans and Providers
C4-23-07
7500 Security Blvd.
Baltimore, MD 21244-1850

A copy of this notice should be sent to both the HCFA central office and regional office plan managers.

M+C organizations that refuse to enter into a Year 2000 M+C contract with HCFA by July 1, and/or that fail to submit an ACRP by July 1, will be considered as having submitted a notice of nonrenewal[13]. Pursuant to §422.506(a)(4), HCFA will not enter into a subsequent M+C contract for a period of five (5) years with an M+C organization unless there are special circumstances that warrant special consideration, as determined by HCFA.

In early May 1999, HCFA will notify all M+C organizations of its intent to authorize renewals, based on the prior years plan performance, in accordance with §422.504(c) by forwarding M+C organizations a Year 2000 M+C contract for signature. It is HCFA's intention to release the Year 2000 M+C standard contract in early May, allowing sufficient time for health plans to carefully consider all contractual provisions prior to returning the contract by the July 1 deadline.

As part of HCFA's Y2K risk mitigation plan, HCFA will require M+C organizations who nonrenew contracts or reduce service areas, to send a notice of nonrenewal to their Medicare enrollees by September 15, 1999. Notification by this date will provide members of nonrenewing plans with an early opportunity to understand the alternatives available to them, and to respond appropriately.

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[13] *Regulations allow an M+C organization to unilaterally terminate an M+C contract with HCFA at any time during the contract year <u>only</u> if HCFA has substantially failed to carry out the term so the agreement. Organizations should <u>not</u> consider provisions for termination as an alternative option to nonrenewal.*

Clarification of Important Issues Related to M+C Plans

ACR Requirements

Section 1854 of the Social Security Act (the Act) and 42 C.F.R. §422.306(a)(1) require M+C organizations to compute a separate[14] Adjusted Community Rate (and associated Benefit Information Form) for each M+C plan it elects to offer to Medicare beneficiaries. At a minimum, each M+C plan must include all Basic Benefits (i.e. Medicare Covered--except hospice--services, and any required Additional benefits) and may include Mandatory Supplemental Benefits for which a mandatory premium is charged. In addition, organizations may offer Optional Supplemental benefits for additional premium collected directly from the Medicare member.

As noted above, all ACRPs must be submitted to HCFA by no later than July 1, 1999. Organizations may submit an ACRP for one M+C plan prior to July 1, for example, while submitting an ACRP for other M+C plans on July 1. However, HCFA will not begin reviewing ACRPs for an M+C organization until all the ACRPs for the organization have been received. HCFA will not accept new ACRs (i.e. new M+C plans) after July 1, 1999 for service areas where the organization already has an M+C plan. However, we will accept[15] a new ACRP for an expansion area.

All approved M+C plans must be offered in accordance with 42 C.F.R.§§422.60 and 422.61, and coverage under plans must be effective as provided in 42 C.F.R.§422.68. HCFA will not approve M+C plans or plan benefits which will not be offered to Medicare eligibles on January 1, 2000[16].

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[14] *Any variations among proposed M+C plans in Additional or Mandatory Supplemental benefits, including cost sharing and premium amounts, require that organizations submit a separate M+C plan and an ACR for HCFA approval. Furthermore, because Point-of-Service (POS) Optional Supplemental benefits will impact the expected utilization and costs of "in-area" Medicare covered, Additional, and Mandatory Supplemental benefits, these benefits also require a separate ACRP.*

[15] *HCFA will not require a new ACRP in cases where an M+C organization is expanding to the remainder of a county area only (i.e. from a partial county to a complete county). In all other cases, M+C organizations must submit an ACRP based on the projected costs and HCFA payment rates of the new, expanded service area.*

[16] *In prior years, HCFA approved certain benefit packages which were to be offered at some time later in the contract year, and not on January 1 of the contract period. These "placeholder" ACRs will not be allowed for CY 2000.*

Enhancements to M+C Plans [ACRs]

Pursuant to 42 C.F.R. §422.300(b)(1) HCFA will allow M+C organizations to enhance approved M+C plans. M+C organizations may enhance approved M+C plan(s) by offering one or a combination of the following:

- An added benefit at no additional cost to the member[17]
- A reduction in premium, or
- A reduction in the copayment charged for a particular service.

M+C organizations may submit proposals to enhance M+C plans at any time during the contract year, but not before the ACRPs submitted by July 1, 1999 are approved[18]. All benefit and pricing changes allowed under §422.300 must be pre-approved by HCFA.

Under 42 C.F.R. §422.300(b)(1), "HCFA's agreement" is required in order for an M+C organization to add benefits or lower premiums or cost-sharing subsequent to the submission of an ACR for the calendar year in question. HCFA has determined that it will not agree to changes in M+C plans under this authority prior to the beginning of the contract year, or January 1, 2000. We anticipate the approval of such changes, as allowed under §422.300(b)(1), to take effect no earlier than February 1, 2000.

This decision is based largely on an important difference between the section 1876 HMO/CMP program and the Medicare+Choice program. Section 1876 did not require the Medicare program to provide comparative information annually to beneficiaries to help them choose between different options available to them. In contrast, the new Medicare+Choice program requires Medicare to give beneficiaries information enabling detailed comparisons between all Medicare options available to them. This information is intended to be used by beneficiaries during the coordinated open enrollment period.

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[17] *Amounts for which the beneficiary would otherwise be liable in the absence of a benefit enhancement will not be considered a cost to the enrollee when this amount must still be paid in the form of cost sharing. For example, if a services costs $100 to the enrollee if not covered by the enhancement, and the enhancement covers $95 of this amount with $5 in cost sharing, the $5 cost sharing amount will not be considered a cost to the enrollee since the enrollee would already be paying this amount.*

[18] *HCFA now expects to complete the approval process of all ACRPs in September 1999, allowing publication of Medicare Compare information on approximately September 15.*

Beneficiaries need to be as confident as possible that the information provided in the annual *Medicare & You* handbook and available on the Internet (*www.Medicare.gov*) is both accurate and reliable. In order to minimize beneficiary confusion and assure that the information provided to beneficiaries for comparison purposes is up-to-date during the November open enrollment period, we believe that the benefits specified by M+C organizations in their ACRPs should not be subject to change prior to the new contract year.

These changes make Medicare's Medicare+ Choice contracting activities more like similar programs administered by other large health care purchasers that provide comparative information to eligible enrollees prior to an annual open enrollment period. Furthermore, allowing changes prior to the contract year tends to undermine the need for organizations to submit accurate ACRPs by the July 1 due date**.** Likewise, allowing immediate changes to approved benefit packages may create unfair advantages to those organizations who receive approval of the ACR before other competitors**.**

It is HCFA's intent to require M+C organizations requesting enhancements to M+C plans to submit an amended Adjusted Community Rate (ACR) proposal, a revised Benefit Information Form (BIF2000) and all associated marketing materials in accordance with 42 C.F.R. §422.80(a)(1) when requesting mid-year enhancements to approved M+C plans. Additional information on the specific requirements and process for requesting enhancements, including information on changes to M+C plans resulting from the acquisition and merger of competing M+C organizations, will be forthcoming.

M+C Plan Service Areas

Section 1852(c)(1)(A) of the Act and regulations at 42 C.F.R. §422.2 require that M+C organizations identify a service area for each M+C plan where the plan is offered to all beneficiaries for a uniform premium, and, in the case of a coordinated care plan or network MSA plan where the organization maintains a network of providers, to meet access and availability standards. As noted in Operational Policy Letter #90, for those organizations who contracted with HCFA in CY 1999, HCFA will administer the M+C service area policy the same way in CY 2000.

Service areas for each M+C plan must be identified as part of the ACRP/BIF2000 submission. Upon approval of the ACR, organizations may not modify plan service areas during a contract year.

Uniform Premiums

Section 1854(b)(1)(C) of the Act and regulations at 42 C.F.R. §422.304(b) requires that M+C organizations offer each M+C plan for the same premium to all individuals within the plan's service area. Furthermore, organizations may not vary the copayment, coinsurance and

deductible amounts charged for both basic (Medicare covered and additional) or supplemental (mandatory and optional) benefits offered within a M+C plan. HCFA policy allows organizations to charge different copayments for a primary care physician office visit than they charge for a specialist office visit. However, M+C organizations may not differentiate the copayment charged for the same service amongst similar types of providers within a M+C plan. As an alternative approach, it is HCFA's opinion that the Act does allow M+C organizations to offer separate M+C plans based on different copayments structures and unique provider networks within the same service area provided that these exclusive provider networks meet all accessibility and availability requirements.

Benefit Design

Federal regulations at 42 C.F.R §422.306 require that the ACR/BIF2000 contain only basic and supplemental *benefits*[19]. Based on this regulation, it is HCFA's opinion that certain services may be included in the ACR/BIF while others must be excluded. For example, services like health education classes, smoking cessation programs, and other wellness programs are considered benefits and should be included in an ACRP/BIF2000. However, items such as life insurance benefits, legal services, and disability insurance are not considered benefits and should not be included in an ACR/BIF2000. Furthermore, discounts or rebates on health related services (e.g. a discount on a health club membership) are considered benefits only <u>if</u> the M+C organization incurs a cost which is fully documented within the ACRP. Discounts or rebates on health care services for which the organization does not incur a cost do not meet the current regulation and must not be listed in the BIF2000.

In addition, M+C organizations must ensure that all M+C plans comply with the following regulations:

- 42 C.F.R §422.100(h)(2) prohibits cost sharing for influenza and pneumococcal vaccinations;

- 42 C.F.R §422.100(h)(1) mandates direct access (self referral) to influenza vaccine and mammography screening;

- 42 C.F.R §422.112(c)(4) prohibits cost sharing amounts for emergency services obtained outside of the plan's network of more than $50 or the amount charged for in-network emergency services, whichever is less.

[19] *Federal regulations at 42 C.F.R 422.2 define a <u>benefit</u> as a health care service that is intended to maintain or improve the health status of enrollees, for which the M+C organization incurs a cost or liability under an M+C plan, and that are approved in the Benefit/ACR process.*

In addition, section 1852(b)(1) of the Act and new regulations at 42 C.F.R §422.100(g) authorize HCFA to deny applications for M+C plans which may promote discrimination, discourage enrollment, steer specific subsets of Medicare beneficiaries to particular M+C plans, or otherwise inhibit access to services.

Value Added Services (VAS):
As noted in Chapter II of the "Medicare Managed Care National Marketing Guide", Value Added Services are products or services made available to the general health plan membership, but which are not included in the ACR/BIF. These products or services can not be advertised or offered to prospective health plan members. Further guidance on "value-added services" will be forthcoming.

Benefit Waiting Periods

M+C organizations may not impose limitations within M+C plans which may restrict a Medicare beneficiary from obtaining a covered benefit at the time the member is enrolled. All M+C plan benefits must be available to all plan members regardless of the length of time that the member has remained enrolled. In other words, members who have remained enrolled in the plan for a certain amount of time may not receive more benefits than are offered to new members. For example, an M+C organization may not require that M+C plan members be enrolled for a period of 6 months, before obtaining coverage for a certain plan benefit (e.g. dental surgery).

Multi-Year Benefits

As noted in Operational Policy Letter #91, HCFA does allow M+C organizations to include multi-year benefits in M+C plans. For example, an M+C plan may include coverage of a single pair of eyeglasses once every three years. However, ACR proposals may include only the annual costs of coverage based on expected utilization during the contract year.

Employer Group Health Plans

HCFA continues to receive questions from M+C organizations related to M+C policies for Employer Group Health Plans (EGHPs). Federal regulations at 42 C.F.R §422.106 clarified several important issues related to EGHPs. For example, M+C organizations may negotiate with independent employer groups to provide more benefits for only those members who enroll through the EGHP. Furthermore, these employer group benefits are not subject to HCFA review. EGHPs may elect to purchase one or several available M+C plan(s) offered within the service area. To facilitate benefit package designs that are tailored to employer benefit requests, organizations have the flexibility to offer more than one M+C plan (or benefit and pricing structure) in a service area.

Nonetheless, some complexities surrounding retiree benefits under EGHPs continue to exist under the Act. For one, the Act does not recognize a member who enrolls through an employer group plan as different from other individuals who enroll directly with the M+C organization. Therefore, all rules regarding M+C benefits (not those benefits negotiated by employer groups) apply equally to all Medicare members. Additional information regarding enrollment periods for EGHPs will be forthcoming.

Standardized Marketing Information

HCFA will require that all M+C organizations use a standardized "Summary of Benefits" (SB) document in pre-enrollment marketing activities in CY 2000. The standardized SB is comprised of 3 sections: (1) a "Beneficiary Information" section which provides important information regarding participation in the Medicare+Choice program; (2) the "Plan Benefit Comparison Matrix" section; and (3) the free form "Plan Information" section. The SB is designed to ensure that Medicare beneficiaries receive consistent and comparable information from all M+C organizations related to M+C plan benefits. The SB will be developed by a team of industry representatives, beneficiary advocacy groups, and government regulators. In addition, HCFA will solicit comments and feedback from the industry and general public prior to releasing a final document. HCFA expects to release a final document for use by all M+C organizations no later than May 31, 1999.

Enrollment Capacity

Regulations at 42 C.F.R §422.306(a)(1)(ii) and §422.60(b) allow organizations to specify an enrollment capacity at the time it submits its ACR proposal (not later than 7/1/99 for CY 2000). Approved enrollment capacities allow an organization to limit the number of enrollees it will accept in a plan during a mandatory enrollment period (e.g, an Annual Election Period, Special Election Period, or Initial Coverage Election Period). Furthermore, regulations at 42 C.F.R. §422.66(d)(2) allow organizations to reserve capacity during an Open Election Period to allow for members who "age-in"[20] during the contract period.

Enrollment capacities should be based on the projected administrative and provider network capacity available for each M+C plan[21]. It is HCFA's intent to allow organizations to adjust

[20] *The term 'age-in' refers to members of non-Medicare products who will convert to the Medicare+Choice product offered by the organization at the time they turn age 65 (i.e., become eligible).*

[21] *HCFA believes that projected enrollment capacities should not be determined based on the potential demand for the M+C plan or the number of subsequent plan nonrenewals in the same service area. Rather, enrollment capacities should predict maximum enrollment numbers based on the capacity of the provider network and the organization's ability to provide administrative services.*

their enrollment capacities during the contract year (both up and down) to account for any unexpected changes (e.g., reductions in the provider network).

Additional information on enrollment capacity requirements and the approval process will be forthcoming.

Continuation Area

In the future, HCFA will release guidance on Continuation Areas.

Required Notifications and Approval to Close Enrollment

Federal regulations at 42 C.F.R §422.62 require that M+C organizations accept enrollments during the Annual Election Period (AEP), Special Enrollment Period (SEP), and an Initial Coverage Election Period (ICEP). M+C organizations may also accept new enrollments for a plan(s) during an optional Open Enrollment Period.

M+C organizations must take certain steps to close enrollment during an optional Open Enrollment Period (OEP). If an M+C organization wishes to elect not to accept enrollment for plans during an optional OEP or to change the closed enrollment period, it must first notify HCFA and give the general public 30 days notice[22] in advance of closing enrollment. For example, if an M+C organization intends to offer a M+C plan continuously throughout the contract year but later decides to close the plan for the remainder of the year, it must notify the public at least 30 days prior to the date the plan will close. If an M+C organization wishes to change its approved closed periods, it must follow the same approval and proper public notification procedures.

Important Changes to the Adjusted Community Rate[23] (ACR) Requirements

[22] *Public notices must be preapproved by HCFA. Appropriate media for informing the public include general announcements which are posted in a public forum, (at a minimum, the notice must be provided in a recognized local newspaper), in the same manner, form, and duration as is usually used for other "M+C plan" advertisements.*

[23] *Information obtained within the ACRPs is considered proprietary and confidential. This information is not releasable under the Freedom of Information Act provisions.*

HCFA will implement a new ACR process for CY 2000. Significant changes reflected in the new ACR include:

New methods for estimating Medicare costs

The new ACR instructions require M+C organizations to develop relative cost ratios (based on actual historical costs) in order to estimate M+C plan costs. Because the cost of providing medical care is a function of both volume (i.e., number of services) and complexity (i.e., price of the service), M+C organizations may compare the direct cost of medical care (incurred in a previous period) between the organization's non-Medicare and Medicare populations to account for differences in utilization characteristics of the respective populations. For those services not previously offered, M+C organizations may use an estimate of the cost to establish an ACR value for the new service.

Consolidation of direct medical care costs

In accordance with federal regulations at 42 C.F.R. §422.306(a), HCFA requires that M+C organizations provide historical cost information for each benefit service category (as noted in lines 1-19 of Worksheet B in the ACRP). For CY 2000, M+C organizations that lack detailed historical cost information may elect to report aggregate medical costs for fewer service categories within the ACRP. The number of service categories reported will depend in part on the ability of the organization's accounting system to identify such data. At a minimum, M+C organizations must report costs for direct medical care, administration, and additional revenue.

M+C organizations that elect to report costs for fewer than all service categories must notify HCFA in writing by no later than June 15, 1999. This notice must identify the specific service categories that will be grouped within the ACRP in addition to the organization's rationale for requiring consolidation. M+C organizations should fax all notices directly to Mr. Frank Regulski at (410) 786-8933. In addition, organizations must include a copy of this notice in the July 1, ACRP submission. If you have additional questions you may contact Mr. Regulski at (410) 786-6278.

The accounting systems of M+C organizations must be able to produce cost figures consistent with the ACR format and in a manner that can be audited. HCFA anticipates that most organizations with a history of offering M+C plans will be able to identify costs for the service categories included the ACR.

Changes to administrative cost component.

The new ACR instructions require M+C organizations to separately identify those costs

previously identified under administrative costs into two categories -- (1) administrative expenses directly related to providing health care services, and (2) other additional revenues used in determining premiums.

Revised methods for calculating the Average Payment Rate (APR)

On January 15, 1999, HCFA published its advance notice of methodological changes for the year 2000 Medicare+Choice payment rates. Further, on March 1, HCFA notified all M+C organizations of the estimated impact resulting from changes to the M+C payment rates effective for CY 2000. While the January 15 notice provided detailed information in regard to the new risk adjustment methodology, the March 1 notice to each M+C organization provided organizations with statistics to assist in the calculation of the average payment rate (APR) needed to complete the CY 2000 ACRP. Organizations should use the information in the March 1 notice (based on September 1998 enrollment statistics) as a guide in determining its specific plan APR for CY 2000. For example, organizations may make adjustments to account for expected variations in the enrollment mix including the expected demographic and risk score distributions of all Medicare enrollees. Organizations should submit a copy of the March 1 notice and a copy of similar tables to reflect projected CY 2000 enrollment distributions in the ACRP submission to support the APR estimate.

Although HCFA will reconcile actual payments based on the submission of late encounter data, organizations will not be allowed to retroactively adjust their APR calculations submitted in the July 1 ACRP. We believe that reconciliation of payments will have little effect on the overall APR estimate because only 10% of payment in CY 2000 will be based on a risk adjustment methodology. Further, to allow retroactive adjustment of the APR based on actual payments without making complementary adjustments to reflect actual costs is inconsistent with Generally Accepted Accounting Principles (GAAP). Accordingly, health plans should use their best estimate in the APR calculation using knowledge of their enrollment and the statistics provided in the March 1 notice.

Point of Service Option

M+C organizations who intend to offer a new[24] Point-of-Service (POS) benefit in CY 2000 must receive approval from HCFA. HCFA's review is designed to ensure that organizations offering POS plans demonstrate necessary administrative capacities in order to comply with regulatory requirements at 42 C.F.R §422.105. In addition, because the offering of POS benefits will impact the expected utilization and costs of non-POS services within the same M+C plan, we require that plans with a POS benefit

[24] *M+C organizations that were previously approved to offer a POS benefit may continue to offer this benefit in the CY 2000, subject to* ***regulatory requirements at 42 C.F.R §422.105, and*** *approval of the ACRP.*

submit a separate and complete ACRP. POS benefits which are offered only as an Optional Supplemental benefit may not be included with a non-POS plan when completing the ACRP. The new ACRP and BIF 2000 format contain a plan type identifier for POS type HMO plans (e.g. HMOPOS).

Both the ACR and BIF2000 contain a separate line item for POS benefits. All costs for providing the POS (out-of-network only) benefit should be reported on line #19 within the ACRP format. Likewise, all POS (out-of-network only) benefits should be described on line #19 of the BIF2000.

Required audit of Adjusted Community Rate (ACR) proposals

Section 1857(d)(1) of the Act and 42 C.F.R. §422.501(d)(1) provide for the annual audit of financial records (including data relating to Medicare utilization, costs, and computation of the adjusted community rate) of at least one-third of the M+C organizations offering M+C plans. Section 1857(d)(2) of the Act and §422.501(d)(2) require M+C organizations to permit HCFA or its designee the right to audit and inspect any books and records of the M+C organization that pertain to the ability of an organization to bear the risk of potential financial losses, services performed, or determination of payments made under the contract.

It is HCFA's intent to begin audits of year 2000 Adjusted Community Rate (ACR) proposals in 1999. However, since the audit of ACRs is a new requirement, and since accounting systems of managed care organizations vary greatly, HCFA believes a transition period is necessary before full implementation can begin. As a result, later this year HCFA will identify a number of managed care organizations which will be subject to an initial audit using the current draft audit program. Organizations selected as part of this transition will be notified in July and will be sent the draft audit program. Following this activity HCFA will revise the audit program as necessary and simultaneously develop audit standards. We expect these revisions and standards to be completed by early 2000. At that time additional audits will be scheduled that will cover the year 2000 ACRs.

Although HCFA is unable to provide specific audit standards at this time, all organizations submitting ACRs for the year 2000 should do so with the expectation of audit, in either 1999 or in 2000. Accordingly, ACRs should be prepared from books and records that have been accumulated and reported using generally accepted accounting principles. Each organization, either as part of the transition or subsequent to it, will be expected to fully support and document all costs entered on the ACR.

Revised Benefit Information Form (BIF 2000)

As announced at the ACR training seminar conducted in October 1998, HCFA has enhanced

the Benefit Information Form (BIF 2000) in preparation for the CY 2000. This form must be completed and submitted by all M+C organizations (and other managed care contractors) by July 1, 1999, the same time that the ACRP is filed.

The revised BIF2000 format has been updated to include new BBA requirements. In addition, this new form is designed to allow M+C organizations to submit complete M+C plan benefit information to HCFA electronically, in conjunction with the ACRP process. Because the benefit and cost information used in Medicare Compare will be gathered in the BIF 2000 tool as part of the contract between HCFA and the M+C organization, there will be no need for a separate submission and validation of the Medicare Compare data. Upon approval by HCFA, Medicare Compare information will be updated regularly based on information submitted in the BIF2000.

Plan Benefit Package (PBP) Pilot

In November 1998, HCFA provided preliminary training on a new benefit input design and strategy referred to as the Plan Benefit Package (PBP). HCFA has received important feedback from training participants and from industry representative groups. Based on this input, HCFA has decided to delay full implementation of the PBP until CY 2001 and to continue to conduct a pilot test of the PBP in CY 2000. Given these decisions, proposed dates for contract Year 2000 activities that were discussed at the November training have been modified as follows:

• Beta Test	March 8-26, 1999	
•	Train Pilot Testers	April 8-13, 1999
• Pilot Test	May 1 -June 30, 1999	

Electronic Submission of the ACR and BIF2000

As noted in a letter to all Medicare Managed Care Organizations dated January 29, 1999, HCFA is currently developing the Health Plan Management System (HPMS), an information system and data exchange mechanism for data related to Medicare managed care health plans. The HPMS will be designed to collect and manage a wide variety of information including quality process and outcome indicators from the Health Plan Employer and Data Information Set (HEDIS) and the Health Outcomes Survey (HOS), customer satisfaction data from the Consumer Assessment of Health Plans Study survey (CAHPS), benefit and copayment information from the ACR and BIF, reporting on Physician Incentive Plans (PIP), appeals data, enrollment and disenrollment information, and financial and payment information.

For CY 2000, M+C organizations must use the HPMS to submit their ACRP, BIF 2000 and physician incentive plan (PIP) reporting. Beginning March 1, 1999, M+C organizations will

use the HPMS to download the ACR spreadsheet and BIF for CY 2000 and may upload their PIP data collection results for CY 1999[25].

[25] *For CY 1999, HCFA has extended the PIP due date until April 30, 1999 to allow organizations additional time to obtain HITS user IDs.*

M+C organizations can access the HPMS (containing the ACR, BIF 2000 and PIP forms and instructions) by means of a secured Internet connection at *www.fu.com/hpms*. HCFA will ensure the secure exchange of these data by implementing Secure Socket Layer (SSL) and encryption technology. In addition to these security measures, HCFA requires that all users obtain a HCFA Identification Tracking System (HITS) user ID in order to access the HPMS beginning March 1, 1999[26]. HCFA will use the HITS user ID to authenticate user access rights and apply the appropriate security levels. M+ C organizations can obtain further information about the HPMS from either *www.fu.com/hpms* or *hpms@nerdvana.fu.com*

ACR, BIF2000 and PBP Pilot Training Seminars

A training seminar was held in November 1998 to present the new ACR methodology and provide the M+C organizations an opportunity to review the new cost schedules before the ACR was issued. In addition, HCFA held a second training session on the Year 2000 ACR process on March 9, 1999. HCFA will conduct an additional training seminar on May 11, 1999 in HCFA's Central Office auditorium in Baltimore, MD. Information necessary to register for this training seminar will be posted on the Logistics Management Institute (LMI), Internet website located at *http://gravity.lmi.org/lmihcfa/acrseminar.htm*.

In addition, HCFA has conducted a 1-day training seminar for each M+C organization participating in the PBP pilot test. The seminar covered the scope of the pilot as well as hands-on-training for using the PBP tool. Additional training seminars will be conducted for all M+C organizations prior to full implementation of the PBP system.

M+C Plan Identification Numbers

HCFA's system traditionally assigned a separate "H- number" (e.g., H3102) to each §1876

[26] A*pplications for a HITS user ID were due to HCFA by February 12 in order to guarantee access by March 1. However, HCFA will continue to process applications on a first-come first-serve basis to ensure that all organizations can obtain, and submit to, HCFA this important information.*

Medicare risk or cost-based contract. This H-number referred exclusively to a single §1876 contract with an associated, contiguous service area. Health plans were required to offer a 'basic benefit' package to all members under the contract. In addition, HCFA systems assigned a separate "P-number" (e.g., P00002) to each managed care organization and each regional geographic component of federally qualified health plans.

The Balanced Budget Act includes certain fundamental changes requiring modifications to HCFA systems. For example, a single M+C organization may offer multiple M+C plans (or plan benefit packages), each with potentially different service areas. HCFA is continuing to create new systems and revise older systems in order to accommodate the BBA. For CY 2000, each M+C organization will continue to be assigned an "H-number" and a "P-number". If your organization operates different coordinate care plan types (e.g. HMO, PSO, and PPO) you will be assigned an 'H-number" for each type. In addition, we expect to assign each M+C plan a separate identifier -- the plan identification number which will be a subset of your "H-number".

Therefore, much of the correspondence you receive from HCFA and the data you submit to HCFA will continue to be according to your "H-number". M+C organizations with different H-numbers are required to submit enrollment and disenrollment statistics and other information to HCFA (e.g. HEDIS, encounter data) for each H-number. In addition, HCFA may send duplicate correspondence to these organizations. For example, your organization should have recently received a letter dated March 1 regarding the impact of risk adjustment. This notice was based on the identifying information for each H-number.

M+C organizations who intend to consolidate H-numbers now assigned to the same legal entity and with the same coordinated care plan type (e.g. all HMOs). M+C organizations should fax all requests to Ms. Rosanna Johnson at (410) 786-8933. If you have additional questions you may contact Ms. Johnson at (410) 786-1148.

We appreciate your understanding and patience as we continue to refine our systems to meet new legislative and regulatory requirements. We will continue to keep you informed of any important changes that may affect your organization.

Other Important Information

HCFA will continue to publish additional guidance related to the Medicare+Choice program and related requirements. Other important information now available on the HCFA web page includes:

OPL99.72 Quality Improvement System for Managed Care (QISMC)

OPL99.73 Clarification Regarding the Notification of Part B-only Grandfathered Members

OPL99.76 Continuation Area and "Visitor/Travel Policy" for Medicare+Choice (M+C) Plans

OPL99.77 Medicare+Choice Provider and Administrative Contracting Guidance

OPL99.78 Reporting Requirements for Medicare Managed Care Organizations in 1999: Health Plan Employer Data and Information Set (HEDIS 1999) Measures that Include the Medicare Health Outcomes Survey (HOS) and the Medicare Consumer Assessment of Health Plans Study

OPL99.79 Update to Medicare Managed Care National Marketing Guide

OPL99.80 Coverage of Dialysis Outside the M+C Service Area for Beneficiaries with End Stage Renal Disease (ESRD)

OPL99.081 Medicare + Choice (M+C) Organizations Appeal and Grievance Data Disclosure Requirements

OPL99.082 The Notice of Discharge & Medicare Appeal Rights (NODMAR) (Formerly known as the Notice of Noncoverage--NONC)

ATTACHMENT -- Year 2000 M+C Contract Instructions

Key Terms and Definitions

M+C organization[27]

Medicare+Choice (M+C) organizations are public or private entities organized and licensed under State law as a risk bearing entity (with the exceptions of provider sponsored organizations receiving federal waivers) that are certified by HCFA as meeting M+C requirements.

The BBA requires an M+C "organization" to perform the following administrative functions: process enrollment and disenrollment information and encounter data to HCFA; submit marketing materials; provide all Medicare-covered benefits and other benefits covered under the contract and approved through the ACRP and BIF2000 in a manner consistent with specified access standards; perform quality assurance; create and carry out all plan procedures for grievances, organization determinations, and appeals; maintain necessary records; provide advance directives; establish and enforce contract procedures related to provider participation; set medical policies; disclose physician incentive plans; receive payment; report financial information; make prompt payments to providers; receive any sanctions invoked by HCFA on any of the organization's plans; and fulfill other contract requirements as specified in the regulation. (Preamble at 34971) Thus, the organization is the business entity which offers a plan and is legally responsible for any liability associated with the delivery or non-delivery of services offered through the plan.

M+C plan

A Medicare+Choice (M+C) plan is a set of health benefits covered under a policy or contract by a M+C organization that includes a specific set of health benefits offered at a uniform premium and uniform level of co-payment(s), co-insurance, deductible(s) to all

[27] *The Balanced Budget Act formally changed the familiar connotations associated with the use of the terms "organization" and "plan". HCFA documents prior to the passage of the BBA used the term "managed care organization" interchangeably with the term "managed care plan" or "health plan."*

Medicare beneficiaries residing in the service area of the M+C plan.(See 42 C.F.R. §422.2)

The M+C plan must include Basic benefits (i.e., Medicare covered benefits and Additional benefits as necessary -- see definition below). M+C plans may also include Mandatory Supplemental benefits and/or Optional Supplemental benefits for additional premiums which the organization collects directly from the plan enrollee.

M+C organizations may offer multiple M+C plans, each requiring a separate Adjusted Community Rate Proposal based on the plan benefits, premiums and cost sharing amounts. M+C plan types are coordinated care plans (including HMOs, PPOs and Provider Sponsored Plans (PSOs)), M+C MSA plans, and M+C private fee-for-service plans. Calculation of the M+C organization's payment is based on enrollment in each plan offered by the M+C organization (i.e., service area, gender, age, health status). The beneficiary enrolls in the M+C organization but elects a M+C plan.

Basic Benefits

The combination of Medicare covered benefits (excluding hospice services) and required additional benefits.

Additional Benefits

Health care services not otherwise covered by Medicare and reductions in premiums or cost-sharing paid for with amounts representing the difference between the plan's ACR and the M+C payment rate.

Mandatory Supplemental Benefits

Health care services not covered by Medicare which beneficiaries must purchase as a condition of enrollment in a M+C plan. Usually those services are paid for by premiums and/or cost sharing. Mandatory supplemental benefits can be different for each M+C plan offered by a M+C organization. M+C organizations must ensure that mandatory supplemental benefits are not used to encourage enrollment from a select group of Medicare eligibles and thus discourage enrollment by members who do not fit within this category.

Optional Supplemental Benefits

Services not covered by Medicare which beneficiaries may choose to purchase for additional plan premium. Optional Supplemental Benefits may be offered individually or combined into groups and may differ for each M+C plan.

NOTE: Additional Terms and Definitions can be located beginning on Page 5 of the

"Instructions for Completing the Adjusted Community Rate Proposal". This information is available at www.fu.com/hpms